



Complete Summary

TITLE

Endoscopy and polyp surveillance: percentage of final colonoscopy reports for patients aged 18 years and older that include documentation of all of the following: pre-procedure risk assessment; depth of insertion; quality of the bowel prep; complete description of polyp(s) found, including location of each polyp, size, number and gross morphology; and recommendations for follow-up.

SOURCE(S)

Physician Consortium for Performance Improvement®, American Society for Gastrointestinal Endoscopy (ASGE), American Gastroenterological Association (AGA), National Committee for Quality Assurance (NCQA). Endoscopy and polyp surveillance physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2008 Aug. 19 p. [6 references]

Measure Domain

PRIMARY MEASURE DOMAIN

Process

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the [Measure Validity](#) page.

SECONDARY MEASURE DOMAIN

Does not apply to this measure

Brief Abstract

DESCRIPTION

This measure is used to assess the percentage of final colonoscopy reports for patients aged 18 years and older that include documentation of all of the following: pre-procedure risk assessment; depth of insertion; quality of the bowel prep; complete description of polyp(s) found, including location of each polyp, size, number and gross morphology; and recommendations for follow-up.

RATIONALE

The goal of this measure is to ensure appropriate documentation of colonoscopy findings and recommendations. The desired outcome is diminished risks to patients and cost savings from a reduction in inappropriate colonoscopies.

- Pre-procedure risk assessment is often used as a surrogate of co-morbidity; research has shown an association between higher class and adverse events. The Clinical Outcomes Research Initiative (CORI) on Colonoscopy Quality Indicators Study of 53 gastroenterology practice sites in 24 states looked at all patients undergoing colonoscopy (n=438,521); in this study, documentation of risk assessment was measured. The American Society of Anesthesiologists (ASA) Classification field was not completed in 10.1% of reports. In 10 of 53 sites, completion rates were less than 90%. When completed, 7.0% of exams were performed in high-risk individuals with ASA class 3 or higher.
- The need for cecal intubation is based on the continual finding that a substantial number of colorectal neoplasms are located in the proximal colon, including the cecum. Numerous studies have shown that physicians routinely do not document the depth of insertion in the colonoscopy report. Quality evaluation of the colon consists of intubation of the entire colon and a detailed mucosal inspection. Cecal intubation improves sensitivity and reduces costs by eliminating the need for radiographic procedures or repeat colonoscopy to complete examination. Careful mucosal inspection is essential to effective colorectal cancer prevention and reduction of cancer mortality.
- Poor bowel preparation is a major impediment to the effectiveness of colonoscopy and impacts the ability to detect polyps and influences the timing of repeat examinations. Poor preparation prolongs cecal intubation time and withdrawal time and reduces detection of both small and large polyps. The economic burden of repeating examinations because of inadequate bowel preparation is substantial. The Clinical Outcomes Research Initiative (CORI) on Colonoscopy Quality Indicators Study of 53 gastroenterology practice sites in 24 states looked at all patients undergoing colonoscopy (n=438,521); in this study, quality of bowel prep recorded was assessed. Findings indicated that 13.9% of reports did not have bowel prep quality reported and in 14 of 53 practices, over 20% did not have bowel prep quality.
- Accurate polyp descriptions are essential to assess disease progression and inform timing of repeat colonoscopy. The timing of follow-up colonoscopy should be tailored to the number, size, and pathologic findings of the adenomatous polyps removed. Gaps in care exist in this aspect of documentation. A recent multi-center study looked at variations in practice and assessed the quality of colonoscopy procedures. Findings indicated that polyp size not recorded in 4.9% of polyps, polyp morphology (pedunculated, sessile, flat) was not reported in 14.7% of reported polyps, and polyp retrieval and submission to pathology was not documented in 4.5% of polyps. These gaps in the documentation of the description of the polyps removed during colonoscopy underscore the need to improve physician adherence to quality patient care.
- Recent evidence suggests that surveillance colonoscopy for post-polypectomy patients in the United States is frequently performed at intervals that are shorter than those recommended in guidelines. In addition, many patient records do not have a recommended follow-up interval recorded. For example, in a 2006 study of 1282 colonoscopy reports, recommendations were consistent with contemporaneous guidelines in only 39.2% of cases and

with current guidelines in 36.7% of cases. Correspondence from the endoscopist included no guidance on follow-up testing in 33.5% of cases.

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Before sedation is begun, a risk assessment is performed to stratify patients into higher or lower-risk-for-complications groups (particularly as pertains to sedation) (Faigel et al, 2006). The physician/nurse team should document the risk assessment. (Risk stratification systems commonly used are the ASA score and the Mallampati score). Visualization of the cecum by notation of landmarks and photo documentation of landmarks should be documented in every procedure. Most important, these include the appendiceal orifice and the ileocecal valve. There should be documentation in the procedure note of the quality of the preparation of the bowel (Faigel et al, 2006). In clinical trials of bowel preparation, terms used to commonly characterize bowel preparation include "excellent," "good," "fair," and "poor." In clinical practice, these terms do not have standardized definitions. In clinical trials on the effectiveness of various regimens for bowel preparation, excellent is typically defined as no or minimal solid stool and only small amounts of clear fluid requiring suctioning. "Good" is typically no or minimal solid stool with large amounts of clear fluid requiring suctioning. "Fair" refers to collections of semisolid debris that are cleared with difficulty. "Poor" refers to solid or semisolid debris that cannot be effectively cleared. The endoscopist should be prepared to perform a total examination and remove all polyps found at the time of the first colonoscopy, although technical factors encountered during colonoscopy may limit completion of the procedure (Davila et al, 2006).

PRIMARY CLINICAL COMPONENT

Colonoscopy; polyp surveillance; final report; documentation

DENOMINATOR DESCRIPTION

All final colonoscopy reports for patients aged 18 years and older

Refer to the original measure documentation for administrative codes.

NUMERATOR DESCRIPTION

Final reports that include documentation of ALL of the following:

- Pre-procedure risk assessment (e.g., American Society of Anesthesiologists [ASA] class, Mallampati score)
- Depth of insertion (i.e., to cecum or other landmark)
- Quality of the bowel prep (i.e., prep was either adequate or inadequate)
- Complete description of polyp(s) found, including location of each polyp, size, number and gross morphology
- Recommendations for follow-up

Evidence Supporting the Measure

EVIDENCE SUPPORTING THE CRITERION OF QUALITY

- A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence
- One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

NATIONAL GUIDELINE CLEARINGHOUSE LINK

- [ASGE guideline: colorectal cancer screening and surveillance.](#)

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Variation in quality for the performance measured

EVIDENCE SUPPORTING NEED FOR THE MEASURE

Krist AH, Jones RM, Woolf SH, Woessner SE, Merenstein D, Kerns JW, Foliaco W, Jackson P. Timing of repeat colonoscopy: disparity between guidelines and endoscopists' recommendation. Am J Prev Med 2007 Dec;33(6):471-8. [PubMed](#)

Lieberman DA, Faigel DO, Logan J, Mattek N, Holub J, Eisen G, Morris C, Smith R, Nadel M. Assessment of colonoscopy quality: results from a multi-center consortium. In press. 2008.

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

Internal quality improvement
National reporting

Application of Measure in its Current Use

CARE SETTING

Physician Group Practices/Clinics

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Physicians

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Individual Clinicians

TARGET POPULATION AGE

Age greater than or equal to 18 years

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component**INCIDENCE/PREVALENCE**

See the "Rationale" field.

ASSOCIATION WITH VULNERABLE POPULATIONS

Unspecified

BURDEN OF ILLNESS

Unspecified

UTILIZATION

Unspecified

COSTS

Unspecified

Institute of Medicine National Healthcare Quality Report Categories**IOM CARE NEED**

Staying Healthy

IOM DOMAIN

Effectiveness

Data Collection for the Measure**CASE FINDING**

Users of care only

DESCRIPTION OF CASE FINDING

All final colonoscopy reports for patients aged 18 years and older

DENOMINATOR SAMPLING FRAME

Patients associated with provider

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions

All final colonoscopy reports for patients aged 18 years and older

Refer to the original measure documentation for administrative codes.

Exclusions

None

RELATIONSHIP OF DENOMINATOR TO NUMERATOR

All cases in the denominator are equally eligible to appear in the numerator

DENOMINATOR (INDEX) EVENT

Diagnostic Evaluation
Encounter

DENOMINATOR TIME WINDOW

Time window is a single point in time

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions

Final reports that include documentation of ALL of the following:

- Pre-procedure risk assessment (e.g., American Society of Anesthesiologists [ASA] class, Mallampati score)
- Depth of insertion (i.e., to cecum or other landmark)
- Quality of the bowel prep (i.e., prep was either adequate or inadequate)
- Complete description of polyp(s) found, including location of each polyp, size, number and gross morphology
- Recommendations for follow-up

Exclusions

None

MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

NUMERATOR TIME WINDOW

Encounter or point in time

DATA SOURCE

Administrative data
Medical record

LEVEL OF DETERMINATION OF QUALITY

Individual Case

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a higher score

ALLOWANCE FOR PATIENT FACTORS

Unspecified

STANDARD OF COMPARISON

Internal time comparison

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

Measure #3: comprehensive colonoscopy documentation.

MEASURE COLLECTION

[The Physician Consortium for Performance Improvement® Measurement Sets](#)

MEASURE SET NAME

[Endoscopy and Polyp Surveillance Physician Performance Measurement Set](#)

SUBMITTER

American Medical Association on behalf of the American Society of Gastrointestinal Endoscopy, American Gastroenterological Association, Physician Consortium for Performance Improvement®, and National Committee for Quality Assurance

DEVELOPER

American Gastroenterological Association
American Society of Gastrointestinal Endoscopy
National Committee for Quality Assurance
Physician Consortium for Performance Improvement®

FUNDING SOURCE(S)

Unspecified

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FINANCIAL DISCLOSURES/OTHER POTENTIAL CONFLICTS OF INTEREST

Conflicts, if any, are disclosed in accordance with the Physician Consortium for Performance Improvement® conflict of interest policy.

INCLUDED IN

Ambulatory Care Quality Alliance
Physician Quality Reporting Initiative

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

2008 Aug

MEASURE STATUS

This is the current release of the measure.

SOURCE(S)

Physician Consortium for Performance Improvement®, American Society for Gastrointestinal Endoscopy (ASG), American Gastroenterological Association (AGA), National Committee for Quality Assurance (NCQA). Endoscopy and polyp surveillance physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2008 Aug. 19 p. [6 references]

MEASURE AVAILABILITY

The individual measure, "Measure #3: Comprehensive Colonoscopy Documentation," is published in "Endoscopy and Polyp Surveillance Physician Performance Measurement Set." This document and technical specifications are available in Portable Document Format (PDF) from the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® Web site: www.physicianconsortium.org.

For further information, please contact AMA staff by e-mail at cqi@ama-assn.org.

NQMC STATUS

This NQMC summary was completed by ECRI Institute on February 26, 2009. The information was verified by the measure developer on April 13, 2009.

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